HOUSE BILL NO. 156

INTRODUCED BY HENRY

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING RECIPROCAL TIME LIMITS FOR HEALTH INSURANCE CLAIM FILING, CLAIM REIMBURSEMENTS, AND CLAIM AUDITS; SETTING A TIME LIMIT FOR HEALTH INSURANCE ISSUERS TO SEEK REIMBURSEMENT OR AN OFFSET OF A CLAIM AND PROVIDING EXCEPTIONS TO THE TIME LIMIT; REQUIRING AN AGREEMENT TO USE CURRENT CLAIM PAYMENTS TO OFFSET PAST OVERPAYMENTS OR INVALID PAYMENTS; AMENDING SECTION 33-22-101, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE AND AN APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Reciprocal limitations on claim filing and claim audits -- time limit for reimbursements or offsets -- exceptions.** (1) Except as provided in subsection (3) ~~or~~, (4), OR (5), if a health insurance issuer limits the time in which a health care provider or other person is required to submit a claim for payment, the health insurance issuer has the same time limit following payment of the claim to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim.

(2) Except as provided in subsection ~~(3) or (4),~~ (3), (4), OR (5), IF A HEALTH INSURANCE ISSUER DOES NOT LIMIT THE TIME IN WHICH A HEALTH CARE PROVIDER OR OTHER PERSON IS REQUIRED TO SUBMIT A CLAIM FOR PAYMENT, a health insurance issuer may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than 12 months after the payment of an invalid or overpaid claim.

(3) ~~(a) If a health insurance issuer receives a final determination of the amount payable by the health insurance issuer on a claim subject to a determination, adjustment, or agreement under subsection (3)(b), the health insurance issuer may perform a review or audit to reconsider the validity of the claim that is a subject of subsection (3)(b) and may request reimbursement for an invalid or overpaid claim under subsection (3)(b) within 12 months from the date upon which the health insurance issuer received notice pursuant to subsection (3)(b) regardless of the time allowed by the health insurance issuer for submission of claims payment.~~ REGARDLESS

OF THE PERIOD ALLOWED BY A HEALTH INSURANCE ISSUER FOR SUBMISSION OF CLAIMS FOR PAYMENT, A HEALTH INSURANCE ISSUER MAY PERFORM A REVIEW OR AUDIT TO RECONSIDER THE VALIDITY OF A CLAIM AND MAY REQUEST REIMBURSEMENT FOR AN INVALID OR OVERPAID CLAIM WITHIN 12 MONTHS FROM THE DATE UPON WHICH THE HEALTH INSURANCE ISSUER RECEIVED NOTICE OF A DETERMINATION, ADJUSTMENT, OR AGREEMENT REGARDING THE AMOUNT PAYABLE WITH RESPECT TO A CLAIM BY:

~~(b) The provisions of subsection (3)(a) apply if a health insurance issuer receives a determination, adjustment, or agreement regarding the amount payable with respect to a claim by:~~

~~(i)~~(A) medicare;

~~(ii)~~(B) a workers' compensation insurer;

~~(iii)~~(C) another health insurance issuer or group health plan;

~~(iv)~~(D) a liable or potentially liable third party; or

~~(v)~~(E) a foreign health insurance issuer under an agreement among plans operating in different states when the agreement provides for payment by the Montana health insurance issuer as host plan to Montana providers for services provided to an individual under a plan issued outside of the state of Montana.

(4) (a) The time limitations on the health insurance issuer in subsections (1) and (2) ~~are tolled~~ DO NOT COMMENCE RUNNING UNTIL THE TIME SPECIFIED IN SUBSECTION (4)(B) if a health insurance issuer pays a claim in which the health insurance issuer:

(i) suspects the health care provider or claimant of insurance fraud related to the claim; and

(ii) has reported evidence of fraud related to the claim to the commissioner pursuant to 33-1-1205.

(b) The time limitation ~~resumes~~ COMMENCES RUNNING on the date that the commissioner determines that insufficient evidence of fraud exists.

(5) THE TIME LIMITATIONS ON THE HEALTH INSURANCE ISSUER IN SUBSECTIONS (1) AND (2) DO NOT COMMENCE RUNNING UNTIL THE HEALTH INSURANCE ISSUER HAS ACTUAL KNOWLEDGE OF AN INVALID CLAIM, CLAIM OVERPAYMENT, OR OTHER INCORRECT PAYMENT IF THE HEALTH INSURANCE ISSUER HAS PAID A CLAIM INCORRECTLY BECAUSE OF AN ERROR, MISSTATEMENT, MISREPRESENTATION, OMISSION, OR CONCEALMENT, OTHER THAN INSURANCE FRAUD, BY THE HEALTH CARE PROVIDER OR OTHER PERSON. REGARDLESS OF THE DATE UPON WHICH THE HEALTH INSURANCE ISSUER OBTAINS ACTUAL KNOWLEDGE OF AN INVALID CLAIM, CLAIM OVERPAYMENT, OR OTHER INCORRECT PAYMENT, THIS SUBSECTION DOES NOT PERMIT THE HEALTH INSURANCE ISSUER TO REQUEST REIMBURSEMENT OR TO OFFSET ANOTHER CLAIM PAYMENT FOR REIMBURSEMENT OF THE CLAIM MORE THAN 24 MONTHS AFTER PAYMENT OF THE CLAIM.

NEW SECTION. **Section 2. Offset agreement.** A health insurance issuer may not collect a claim overpayment or other reimbursement by offsetting another claim payment made to a health care provider or other person unless the health care provider or other person has previously authorized the health insurance issuer in writing to recover an overpayment or other reimbursement by offsetting a future claim payment.

Section 3. Section 33-22-101, MCA, is amended to read:

"33-22-101. Exceptions to scope. ~~Parts~~ (1) SUBJECT TO SUBSECTION (2), PARTS 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, 33-22-125, 33-22-129, 33-22-130 through 33-22-136, 33-22-140, 33-22-141, 33-22-142, ~~[section 1], [section 2],~~ 33-22-243, and 33-22-304, and part 19 of this chapter do not apply to or affect:

~~(1)~~(A) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;

~~(2)~~(B) any group or blanket policy;

~~(3)~~(C) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance that:

~~(a)~~(I) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

~~(b)~~(II) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity ~~in the event that~~ if the insured or annuitant becomes totally and permanently disabled~~,~~ as defined by the contract or supplemental contract;

~~(4)~~(D) reinsurance.

(2) [SECTIONS 1 AND 2] APPLY TO GROUP OR BLANKET POLICIES."

NEW SECTION. **Section 4. Codification instruction.** [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [sections 1 and 2].

NEW SECTION. **Section 5. Effective date -- applicability.** [This act] is effective January 1, 2006, and applies to claims made on or after January 1, 2006.

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